MDR Tracking Number: M5-05-0350-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-27-04.

The IRO reviewed range of motion testing, muscle testing, manual therapy techniques, office visits, therapeutic procedures (97110), aquatic therapy, whirlpool, gait training, and physician review with report (96004) on 12-3-03 to 5-7-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO deemed the range of motion testing on 12-3-03, the whirlpool and therapeutic procedures (97110) on 5-4-04, and the manual therapy and whirlpool on 5-6-04 were medically necessary. The IRO agreed with the previous adverse determination that the remaining services and procedures were not medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO Decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 11-4-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

On 1-4-05, the respondent submitted paid EOBs for dates of service 12-3-03, 1-19-04, 3-9-04, and 4-20-04.

On 1-20-05 the requestor submitted an updated table to reflect the recent payments received.

Code 97140-59 billed for date of service 11-25-03 was denied as "G – this procedure is mutually exclusive to another procedure on the same date of service." The carrier did not specify the other procedure; therefore, recommend reimbursement of $26.32 x 125% = $32.90.

Code 95833 billed for date of service 12-3-03 was billed @ $53.00 for one unit and the carrier paid $21.32 per new EOB. The MAR is $39.42 x 125% = $49.28. Recommend additional reimbursement of $27.96.

Code 97022 billed for date of service 3-9-04 was billed @ $20.00 for one unit and the carrier paid $18.47. The MAR is $14.45 x 125% = $18.06. No further reimbursement recommended.

Code 97110 billed for date of service 5-3-04 was billed @ $76.00 for two units. Neither party submitted an EOB. Requestor submitted convincing evidence of request for EOB per Rule 133.308(f)(3). Therefore, this review will be per the Medicare Fee Guideline. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily note did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

Code 97116 billed for date of service 5-3-04 was billed @ $32.00 for one unit. Neither party submitted an EOB. Requestor submitted convincing evidence of request for EOB per Rule 133.308(f)(3). Therefore, this review will be per the Medicare Fee Guideline. Daily note supports services rendered. Recommend reimbursement of $24.47 x 125% = $30.59.

Code 99213 billed for date of service 5-3-04 was billed @ $70.00. Neither party submitted an EOB. Requestor submitted convincing evidence of request for EOB per Rule 133.308(f)(3). Therefore, this review will be per the Medicare Fee Guideline. Daily note supports services rendered. The MAR is $52.14 x 125% = $65.18. Requestor is seeking $65.17. Recommend reimbursement of $65.17.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 11-25-03 through 5-6-04 as outlined above.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 28th day of January 2005.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

Enclosure: IRO Decision

December 23, 2004
January 13, 2005
January 17, 2005
January 20, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT

Re: Medical Dispute Resolution
MDR #: M5-05-0350-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ___:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is licensed in chiropractic and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel

GP:thh

REVIEWER'S REPORT
M5-05-0350-01
Ruben Chavez

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor:
- letter of medical necessity
- office and physical therapy notes 11/25/03 – 05/07/04
- FCE's 12/03/03 – 03/25/04

Information provided by Respondent:
- correspondence

Information provided by Pain Management Specialist:
- office notes 01/09/04 – 04/02/04
- procedure reports 02/27/04 – 04/30/04

Information provided by Orthopedic Surgeon:
- office note 03/02/04

Clinical History:
Patient is a 28-year-old male who, on ___ was injured on his job resulting in a sharp pain in his lower back that radiated into his left lower extremity. After first being seen by the company doctor, he presented himself to a doctor of chiropractic who initiated conservative chiropractic care, including physical therapy. Despite this, beginning in February of 2004, he underwent a series of three epidural steroid injections, followed by post-injection physical therapy and rehabilitation.

Disputed Services:
Range of motion measurements/report, muscle testing-manual, manual therapy techniques-mobilization manipulation, office visits, therapeutic procedure-range of motion, therapeutic procedure-aquatic, application of a modality-whirlpool, physician review/report, and therapeutic procedure-gait training during the period of 12/03/03 thru 05/07/04.

Decision:
The reviewer partially disagrees with the determination of the insurance carrier as follows:

MEDICALLY NECESSARY:
- 97140 - manual therapy techniques 05/06/04
- 97022 – whirlpool modalities 05/04/04 & 05/06/04
- 97110 – therapeutic procedures 05/04/04
- 95851 – range of motion measurement w/report 12/03/03

NOT MEDICALLY NECESSARY:
All other remaining services and procedures in dispute other than those specified above.

Rationale:
In this case, the medial records submitted adequately documented that a compensable injury to the lower back had occurred, and that there was lumbo-

/pelvic joint dysfunction and decreased range of motion that would necessitate the performance of manual therapy techniques. In addition, the records demonstrated that epidural steroid injections had been delivered, so post-injection therapy in the form of land strengthening exercises (97110) and whirlpool treatments (97022) were also medically necessary. Also, it was appropriate to periodically monitor range of motion in the affected area, so this procedure (95851) was supported.

However, with respect to the therapeutic exercises prior to 05/03/04, the daily "Clinical Notes"(S.O.A.P. Notes) for dates of service 03/01/04 and 03/11/04 indicated that aquatic therapy was performed on those dates, NOT land based exercise. No mention of therapeutic exercises was made at all on those patient encounters. Therefore, the medical necessity of therapeutic exercise (97110) on those dates of service was not supported.

Furthermore, the remainder of the office visits (99213) occurred during a prescribed treatment plan rendered in support of the injection procedures. Therefore, based on CPT [1], there was no support for the medical necessity of providing this high a level of Evaluation and Management (E/M) service on a "routine basis" at each and every patient encounter, and particularly not during an already-established treatment plan. Therefore, these additional office visits were denied.

Insofar as the gait training (97116) and the motion analysis studies (96004) were concerned, there was nothing in the documentation submitted whatsoever that supported the medical necessity of these procedures/evaluations. In terms of the gait training, other than the diagnosis which was reported as "Difficulty in walking involving joint of pelvic region and thigh, 719.75," nothing specific was offered in either the examinations or the daily notes that suggested what was aberrant or abnormal about the patient's gait that would require this service (and, according to ICD-9-CM[2], reporting diagnosis code 719.75 for difficulty in walking *excludes* abnormality of gait). Gait wasn't mentioned at all. And, in the required medical examiner's report, he stated, "Gait was normal." In terms of the motion analysis studies, one LMRP Medicare service [3] states the following in regard to the 96004 CPT code:

> *"Motion analysis has been used to evaluate walking, most frequently in children with neuromuscular disorders such as cerebral palsy or meningomyelocele. These motion analysis laboratories use computer-based analysis of video-taping (from front, back and side), and 3-D kinematics, tracking retroreflective markers along the legs. Surface electromyography is used to*

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[1] *CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised*. (American Medical Association, Chicago, IL 1999),

[2] *ICD-9-CM, International Classification of Disease,* 9th Revision, Clinical Modification, Fifth Edition

[3] Empire Medicare Services, *The Medicare News Brief – New Jersey and Downstate New York,* MNB-1 Policy, June 2002

identify information about the firing pattern of individual muscles during walking, and needle electromyography is used during this study to assess the tibialis posterior muscle which is a deep muscle far from the skin surface (dynamic EMG). Plantar pressure and foot plate devices are able to measure the pressure distribution on the foot and the direction of force, while walking and during stance phase. Stride characteristics and 3-D kinematics are included in this service. The studies are performed in a dedicated facility-based motion analysis laboratory. The entire laboratory analysis may take 2-4 hours. Approximately 65 percent of children studied in one laboratory had cerebral palsy, and another 20 percent had meningomyelocele (see reference #5). This policy only addresses the use of motion analysis as contained and described in CPT codes 96000 - 96004 (CPT 2002)."

Not only were none of these factors present in the documentation that would warrant the performance of this service, the daily "Clinical Notes" failed to describe or even mention this service. Therefore, its medical necessity was not supported.

Finally, regarding the aquatic therapeutic exercises (97113), the documentation and medical records submitted failed to adequately document the clinical rationale to support why this particular service was necessary versus a and-based exercise program. There was no mention of the physical limitations or complications in this particular patient's circumstances that warranted a less weighted environment to perform strengthening exercises. Therefore, the medical necessity of this service was also not supported.